Safety Clicks

Learning from others' mistakes

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Human Behavioral Factor #5: Culture

By Shannon Smith

In our previous articles, we have discussed human behavior and how it is often a main contributing cause of accidents. We also reasoned that if we could change the top 5 human behaviors, we could eliminate 3 out of 4 accidents and injuries. The #5 human behavior at the root cause of incidents and accidents is culture. But what is culture?

Basically, culture is the character and personality of a group based on values, traditions, behaviors and attitudes.

At TDI, we encourage everyone to "be their brother's keeper". That means look out for each other, **STOP WORK** if you see something that could hurt someone and to remember we are all on the same team.

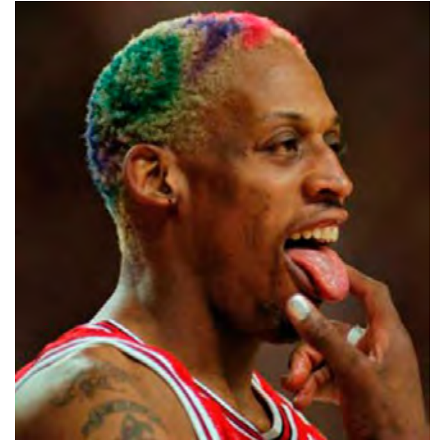
Every member of the team creates a part of that culture whether they intend to or not. As a member of the TDI team, what's your contribution? When you show up, do you improve the situation, or make it worse?

Are you the guy that hogs the ball, blames others for his mistakes or just likes to argue with the referee? Are you the guy that sets up the shots, defends the star player and helps the team win? Do you spend most of your time on the bench while others do the heavy work? How do you think your coworkers would rate you?

Cultural issues, lack of basic skills and teamwork were common factors of Navy incidents

After a series of serious incidents aboard navy vessels leading to the removal of several officers and a fleet admiral, along with many lives lost, the US Navy conducted a comprehensive review of fleet operations over the last ten years. A very condensed summary of the 177 page report follows.

In recent incidents, U.S. Navy ships sustained catastrophic flooding, loss of critical systems, and 17 Sailors were killed. In each incident, these ships failed as a team to use available information to sustain situational awareness on the Bridge and prevent hazardous conditions from developing.



Yeah, he's good. But would you want him as a teammate?

"You can teach someone pretty much anything, but you can't teach him not to be a jerk."

Nedal Ahmad

TOP Safety Card Hits
(Fleetwide last month)

Housekeeping	14
Safety Attitude	5
Communications	3

Cultural issues, lack of basic skills and teamwork were common factors of Navy incidents (continued)

The Review Team identified five areas in need of improvement: Fundamentals, Teamwork, Operational Safety, Assessment and Culture.

Fundamentals– in many of the incidents, the crew did not understand how to properly use the ship systems and controls. The controls had not been standardized and varied from vessel to vessel– even among ships of the same type. In one incident, there were no posted procedures on how to transfer throttle or steering control and the resulting confusion among the crew resulted in steering control being transferred to various stations four times in the two minutes leading to the collision.

Teamwork— A common element in many of the incidents was lack of situational awareness leading to miscommunications between an inexperienced crew and failure to communicate between affected vessels. The report states**, "Each of the four Bridge and ... teams involved in the mishaps did not work with each other to solve problems as an effective team."** It further states**, "Bridge and other … watchstanders did not perform their duties as primary advisors to the Officer On Duty for the safe navigation of the ship as required by the Commanding Officer's Standing orders…"**

Operational Safety– In each incident, the crew were unaware that small failures to follow basic navigational rules was putting them in a hazardous position and failed to take emergency action until it was to late to avoid collision, allision or grounding. The leaders and teams failed as maritime professionals by not following safe navigational practices.

Assessment— "Safety programs and safety reporting and analysis systems to develop and promulgate lessons learned and feedback from significant events are also inadequate."

Culture— Sailors take great pride in a "can do" attitude. The Navy values this culture because it needs leaders who can confidently manage their ships and crews as well as their operational risks. **But can-do should never mean must-do.** The manifestation of that culture is highly dependent on individual leaders.

Crews perceived their Commanding Officer was unable to say "no" regardless of consequence to the vessel crew. A climate intolerant of dissenting views or questions prevents effective teamwork . ***(Failure to use or recognize STOP WORK authority)***

All watchstanders, from the most junior Sailor to the CO, have an obligation to speak up when they see a deviation from procedure or dangerous situation developing. Command leadership, regardless of experience and rank, must have the humility to listen to the backup and consider it in their decisions. By example, this will encourage their subordinates to do the same.

Crews are safety conscious, but tend not to take advantage of rest hours to get sufficient rest. Sailors need to be proactive about managing their personal fatigue and reach out to leadership if they feel it creates unacceptable risk.